Continuation Guidance for Cooperative Agreement on Public Health Preparedness and Response for Bioterrorism – Budget Year Four

Program Announcement 99051
May 2, 2003

A. INTRODUCTION:

The Centers for Disease Control and Prevention (CDC) announces the availability of FY 2003 funding for continuation of the cooperative agreements to upgrade state and local public health jurisdictions' preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. This document is provided to assist states and other eligible entities in developing continuation applications for Budget Year Four (August 31, 2003-August 30, 2004) of a project period that began August 31, 1999.

Please note that this guidance includes significant new information about recipient activities related to smallpox preparedness activities and chemical laboratory (Focus Area D) enhancements. Also included in this guidance are instructions for documenting certain recipient activities that apply to both this cooperative agreement and the hospital preparedness cooperative agreement administered by the Health Resources and Services Administration (HRSA) – referred to herein as "Cross-Cutting Activities".

States and other entities that currently receive bioterrorism cooperative agreement funds from CDC should augment, complement, and closely coordinate the supported activities with those supported by other CDC programs (e.g., Emerging Infections Program, infectious disease Epidemiology and Laboratory Capacity Program, National Electronic Disease Surveillance System, Assessment Initiative, and Hazardous Substances Emergency Events Surveillance) as well as the Metropolitan Medical Response Systems program, which is sponsored by the Department of Homeland Security. Since bioterrorism and other public health emergencies do not respect geopolitical lines, applicants should consider how preparedness will be strengthened within states, among adjacent states, and/or across international borders to better coordinate response plans on a regional basis to avoid duplication of effort, fill in identified gaps, and maximize the leverage of limited resources of the relevant local, state, federal and international agencies. CDC encourages applicants to build upon activities currently underway in their jurisdictions.

Applications shall provide evidence of a process that demonstrates consensus, approval or concurrence between state and local public health officials for the proposed use of these funds. Bioterrorism events will occur at the local level; the capacity to respond must be assured at both the state and local level. Because of the high degree of variability in financing, organization, and governance of state and local health departments across the United States, there is no single best approach for achieving such consensus; however, assurance that both appropriate state and local capacity development is to be achieved must be documented. The purpose of such a process is

to demonstrate that a significant portion of local public health officials including those serving a significant portion of the state's population concur with the proposed use of funds. The intent of this provision is to ensure meaningful collaboration between state and local public health officials, while not enabling any one health official to stall the entire statewide process. Local capacity can be built through direct allocation of funds to local levels and through allocations to support state or sub-state regional capacities that directly benefit local communities. Even in those states that operate local health departments, appropriate local capacity development must be ensured. The focus of funding allocations should be on the benefit achieved, not on who spends the dollars.

B. AVAILABILITY OF FUNDS:

Funding Amount: Approximately $870 million in FY 2003 monies is available for budget period 4, which begins on August 31, 2003, and ends on August 30, 2004. State and City awardees will receive $5 million per awardee plus an amount proportional to their populations as reflected in the U.S. Census estimates for July 1, 2001. Due to their demographic characteristics and unique programmatic needs, American Samoa, the Virgin Islands, Guam, the Northern Mariana Islands, the Marshall Islands, the Federated States of Micronesia and Palau will receive $500,000 per awardee plus a population-based allocation. Awardee-specific funding levels are provided in Annex B. Any advances on FY 2003 funding that some awardees may have received prior to August 31, 2003 are not reflected in Annex B and should be subtracted from the amounts shown to provide the remaining amounts for which awardees are eligible in August 2003.

Use of Funds: Applicants must identify their proposed allocation of funding by Focus Area in their submissions for Budget Period Four. However, monies may be reallocated among focus areas during the year, provided the following conditions are met: Awardees must notify the CDC Grants Office and copy their CDC Project Officer on all funding reallocations. Prior approval must be obtained for all funding reallocations totaling more than 25% of total Budget period 4 funding, or $250,000 (whichever is less).

NOTE: IN ACCORD WITH THE HOMELAND SECURITY ACT OF 2002, ON MARCH 1, 2003, THE DEPARTMENT OF HOMELAND SECURITY BECAME RESPONSIBLE FOR THE FISCAL YEAR 2002 FUNDS APPROPRIATED ORIGINALLY TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THIS PURPOSE. ACTIVITIES UNDER CRITICAL CAPACITY #4 (SEE ATTACHMENT A: STRATEGIC NATIONAL STOCKPILE) ARE THEREFORE NO LONGER ELIGIBLE FOR FY2003 SUPPORT BY CDC OR OTHER COMPONENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. HOWEVER, ANY FUNDS CARRIED OVER FROM PREVIOUS FISCAL YEARS UNDER THIS CDC COOPERATIVE AGREEMENT MAY BE APPLIED TO CRITICAL CAPACITY #4. THE DEPARTMENT OF HOMELAND SECURITY IS FORMULATING ITS PLANS FOR FUNDING THIS ACTIVITY. AS SOON AS THIS INFORMATION IS AVAILABLE, CDC WILL PROVIDE AN ADDENDUM TO THIS GUIDANCE REGARDING FUNDING FOR CRITICAL CAPACITY #4.

Cooperative agreement funds under this program may not be used to replace or supplant any current state or local expenditures.

Unobligated Funds: Applications must include a projection of the amount of FY2002 supplemental funds (awarded in February and June, 2002) that will be unobligated on August 30, 2003 and report this estimate for each focus area on a separate interim financial status report (FSR). At the awardee's request, CDC will consider requests to carry forward up to 75% of the estimated unobligated funds as reflected on the interim FSR. Upon approval by CDC, up to 75% of estimated unobligated funds will be awarded in addition to new (FY 2003) funds on August 31, 2003. Requests to carry-forward unobligated supplemental FY 2002 funds must be made in writing to the CDC Grants Office by July 1, 2003, under separate cover from the continuation application. Carry-over requests must include a cover letter, a detailed budget and budget justification. Applicants are encouraged to submit carry-over requests to complete critical projects undertaken in response to prior CDC guidance that were begun but not completed in the previous budget period and/or to support unforeseen needs within the scope of this cooperative agreement. Estimated FY2002 supplemental unobligated funds that are not adequately justified or for which a written carry-over request is not received by July 1, 2003 will be brought forward in lieu of new (FY2003) funds.

Direct Assistance (DA): Subject to approval by the Program Grants Office, applicants may request that a portion of their award funds be awarded in Direct Assistance funds to be obligated to federal contracts. However, due to recent changes in CDC accounting procedures, DA funds will now have to be spent (or obligated to a contract) within the same FY they are awarded. Redirection of funds from financial assistance to DA after award will no longer be allowed. (Please see Appendix 5 for additional details and instructions.)

C. NEW/EXPANDED ACTIVITIES

1. **Cross Cutting Activities:** The Department of Health and Human Services (HHS) is funding activities at the state and local levels for public health preparedness through this cooperative agreement and for hospital preparedness through HRSA. To ensure that all preparedness activities are coordinated and integrated at the state and local levels, applicants should address recipient activities that are identified in Attachment X, Cross-Cutting Activities.

This Cross-Cutting Activities section is identical in both the CDC and the HRSA guidance. In the HRSA guidance, this section appears in the body of the guidance; in the CDC guidance, it appears as Attachment X. **Responses to this section should be identical whether submitting for CDC or HRSA funding**. Thus the responses need be prepared only once and copies inserted in the separate submissions to CDC and to HRSA.

2. **Smallpox Preparedness Activities:** This guidance addresses smallpox programs by integrating current, ongoing recipient activities related to smallpox preparedness into the existing framework of critical program capacities required for an adequate response to bioterrorism and

other public health emergencies. These activities are described in Focus Area Attachments A, B, C, F and G. The program goals and recipient activities related to smallpox preparedness are also provided in a consolidated format in Annex A. Awardees should detail smallpox activities in their workplans within the associated Focus Areas.

3. **Focus Area D – Chemical Laboratories**: FY 2003 funds are available for Focus Area D – Lab Capacity for Chemical Agents. The goal is to expand chemical laboratory capacity in all jurisdictions to prepare and respond to chemical terrorism incidents and other chemical emergencies. This program expansion will allow for full participation of chemical terrorism response laboratories in the Laboratory Response Network (LRN).

The purpose of this focus area is to develop nationwide laboratory capacity that provides rapid and effective analysis of clinical specimens (e.g., blood and urine) for chemical agents likely to be used in terrorism. These laboratory measurements will help guide public health management of a chemical terrorism event by identifying the chemical agent(s) used, determine who has been exposed and how much exposure each person has had. This nationwide capability has three levels of laboratory capacity. Level-One laboratories develop and maintain capacity to collect and transport clinical specimens to other laboratories for analysis for chemical agents. Awards for Level-One laboratories will be limited to $400,000 per awardee.

Level-Two and Level-Three laboratories are categorized as enhanced capacity. Level-Two laboratories perform chemical agent measurements of **moderate complexity,** including cyanide-based compounds, arsenic, mercury, other heavy metals, and lewisites. To be eligible for Level-Two funding, the recipient must document a basic level of staff competency in analytical/clinical chemistry and laboratory quality control in measurements of low concentrations of chemicals or metabolites in clinical samples. Development of Level-One and Level-Two capabilities may be concurrent activities.

Level-Three laboratories have Level-Two responsibilities and in addition perform chemical agent measurements of **high complexity,** including nerve agents, mustards, tricothecene mycotoxins, selected incapacitating agents, and selected toxic industrial chemicals. The five laboratories already funded (California, Michigan, New Mexico, New York, and Virginia) are considered Level-Three laboratories. These states are eligible for up to $1,500,000 per state to maintain Level-Three capacities. It is CDC's intent to increase the number of laboratories in Level-Three from five to as many as ten in the future. To be eligible for Level-Three, a Level-Two lab must demonstrate analytical competency for all Level-Two chemical agents.

Further detail, including related activities, can be found in the Focus Area D Attachment.

4. **Planning for Mental Health Services:** Important additions to this new cooperative agreement are recommendations and requirements to address needs and direct activities to issues of psychological health and their behavioral manifestations. This represents a strongly recognized need that the Nation prepare to protect both the physical and psychological health of those potentially victimized by terrorism.

D. WORKPLAN CONTENT

1. HRSA/CDC Cross-Cutting Coordination

Recipients must coordinate planning and program implementation activities to ensure that state and local health departments, hospitals, and other health care entities are able to mount a collective response featuring seamless interaction of their event-specific capabilities in the following areas:

- Incident management
- Joint advisory committee for CDC and HRSA cooperative agreements
- Laboratory connectivity
- Laboratory data standard
- Jointly funded health department/hospital activities
- Integration of surveillance activities
- Coordination with Indian tribes
- Populations with special needs
- Psychosocial consequences of bioterrorism and other public health emergencies
- Education and training
- Involvement of academic health centers
- Interoperability of IT systems

For example, while public health departments would play the predominant role in a public health emergency requiring mass distribution of vaccine or antibiotic prophylaxis, hospitals and other health care entities would carry the primary burden in the wake of a mass casualty incident. Integration of efforts must also include coordination of hospital and public health preparedness activities with those of public safety and emergency management agencies, especially with respect to activities funded by the Department of Homeland Security and/or other federal agencies. State awardees should actively support efforts by counties and municipalities to enhance their readiness for public health emergencies, including their capacity to rapidly accommodate state and federal assets such as the Strategic National Stockpile and emergency response teams.

Several Focus Areas, such as information technology, training/education, risk communication and public information are fundamental to all bioterrorism and public health preparedness efforts and therefore are cross-cutting in nature.

2. Focus Areas for Public Health Preparedness

Applicants' public health preparedness should address the *Critical Capacities and Critical Benchmarks* listed for each Focus Area summarized in Table 1 below. *Critical Capacities* are the core expertise and infrastructure to enable a public health system to prepare for and respond to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies. Awardees must ensure that these Critical Capacities are fully addressed in their

work plan by responding to the *Recipient Activities* defined in attachments A-G. *Critical benchmarks* are those recipient activities that should be prioritized and fully achieved during the budget period. Recipient activities not designated as *critical benchmarks* should be undertaken with the understanding that they may take longer than the current budget period to accomplish. In addition, activities associated with *critical benchmarks* achieved in previous funding years should be continued in Budget Period 4, as appropriate.

Recipient activities related to smallpox preparedness are found under the relevant critical capacities in the Focus Area attachments. These smallpox activities relate directly to those already addressed in previous Guidances specific to smallpox efforts. As applicable, awardees should address and respond to these activities in collaboration with all other activities. Work plans and funding requests for Budget period IV should reference *current* smallpox vaccination preparations related to previous CDC guidance and any planned expansions of their program as current funding levels permit.

As funding permits, awardees may also consider the *Enhanced Capacities* for each Focus Area. Enhanced Capacities are the additional expertise and infrastructure (i.e., over and beyond the Critical Capacities). Enhanced Capacities should be addressed only after Critical Capacities have been achieved or are well along in development.

CDC intends to transition *critical capacities* to *readiness goals* and *readiness indicators* in future program announcements, which will assist CDC and awardees in measuring preparedness.

Table 1: Critical and Enhanced Capacities by Focus Area

Focus Areas: Critical and Enhanced Capacities

Focus Area A - Preparedness Planning and Readiness Assessment:
Establish strategic leadership, direction, assessment, and coordination of activities (including Strategic National Stockpile response) to ensure statewide readiness, interagency collaboration, local and regional preparedness (both intrastate and interstate) for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies

Critical and Enhanced Capacities:

- *Critical:* To establish a process for strategic leadership, direction, coordination, and assessment of activities to ensure state and local readiness, interagency collaboration, and preparedness for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies
- *Critical:* To conduct integrated assessments of public health system capacities related to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies to aid and improve planning, coordination, and implementation
- *Critical:* To respond to emergencies caused by bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies through the development, exercise, and evaluation of a comprehensive public health emergency preparedness and response plan
- *Critical:* To effectively manage the CDC Strategic National Stockpile (SNS), should it be deployed – translating SNS plans into firm preparations, periodic testing of SNS preparedness, and periodic training for entities and individuals that are part of SNS preparedness
- *Enhanced:* To ensure public health emergency preparedness and response through the development of necessary public health infrastructure
- *Enhanced:* To recruit, retain, and fully develop public health leaders and managers with current knowledge and expertise in advanced management and leadership principles who will play critical roles in responding to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies
- *Enhanced:* To ensure that public health systems have optimal capacities to respond to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies

Focus Area B – Surveillance and Epidemiology Capacity:
Enable state and local health departments to enhance, design, and/or develop systems for rapid detection of unusual outbreaks of illness that may be the result of bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. Assist state and local health departments in establishing expanded epidemiologic capacity to investigate and mitigate such outbreaks of illness

Critical and Enhanced Capacities:

- *Critical:* To rapidly detect a terrorist event through a highly functioning, mandatory reportable disease surveillance system, as evidenced by ongoing timely and complete reporting by providers and laboratories in a jurisdiction, especially of illnesses and conditions possibly resulting from bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies
- *Critical:* To rapidly and effectively investigate and respond to a potential terrorist event as evidenced by a comprehensive and exercised epidemiologic response plan that addresses surge capacity, delivery of mass prophylaxis and immunizations, and pre-event development of specific epidemiologic investigation and response needs
- *Critical:* To rapidly and effectively investigate and respond to a potential terrorist event, as evidenced by ongoing effective state and local response to naturally occurring individual cases of urgent public health importance, outbreaks of disease, and emergency public health interventions such as emergency chemoprophylaxis or immunization activities
- *Enhanced:* To rapidly detect and obtain additional information about bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies through other core, cross-cutting health department surveillance systems such as vital record death reporting; medical examiner reports; emergency department, provider, or hospital discharge reporting; or ongoing population-based surveys
- *Enhanced:* To rapidly detect and obtain additional information about bioterrorism, other infectious disease outbreaks, or other public health threats or emergencies by accessing potentially relevant pre-existing data sets outside the health department, or through the development of new active or sentinel surveillance activities
- *Enhanced:* For effective response through the creation or strengthening of pre-event, ongoing working links between health department staff and key individuals and organizations engaged in healthcare, public health, and law enforcement

C - Laboratory Capacity – Biologic Agents:
Ensure that core diagnostic capabilities for bioterrorist agents are available at all state and major city/county public health laboratories. These funds will enable state or major city/county laboratories to develop the capability and capacity to conduct rapid and accurate diagnostic and reference testing for select biologic agents likely to be used in a terrorist attack

Critical and Enhanced Capacities:

- *Critical:* To develop and implement a jurisdiction-wide program to provide rapid and effective laboratory services in support of the response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies
- *Critical:* As a member of the Laboratory Response Network (LRN), to ensure adequate and secure laboratory facilities, reagents, and equipment to rapidly detect and correctly identify biological agents likely to be used in a bioterrorist incident

Focus Area D - Laboratory Capacity – Chemical Agents:
Ensure that all state public health laboratories have the capacity to measure chemical threat agents in human specimens (e.g. blood, urine) or to appropriately collect and ship specimens to qualified LRN partner laboratories for analysis. As part of the LRN, to establish a network of public health laboratories for analysis of chemical threat agents

Critical and Enhanced Capacities:

- *Critical:* (Level-One Laboratories): To develop and implement a jurisdiction-wide program that provides rapid and effective laboratory response for chemical terrorism by establishing competency in collection and transport of clinical specimens to laboratories capable of measuring chemical threat agents
- *Enhanced:* (Level-Two Laboratories): In addition to establishing Level-One capacity, Level-Two Laboratories are to establish adequate and secure laboratory facilities, reagents, and equipment (e.g. ICP-MS, GC-MSD) to rapidly detect and measure in clinical specimens Level-Two chemical agents (such as cyanide-based compounds, heavy metals, and lewisites). Currently, CDC methods for Level-Two chemical agents use analytical techniques of inductively coupled plasma mass spectrometry and gas chromatography mass spectrometry. The list of Level-Two chemical agents may expand as better methods are developed. Tandem mass spectrometry methods are not required for Level-Two chemical agents
- *Enhanced:* (Level-Three Laboratories): In addition to maintaining Level-One and Level-Two capacity, Level-Three laboratories are to establish adequate and secure laboratory facilities, reagents, and equipment (e.g., tandem mass spectrometer) to rapidly detect and measure in clinical specimens Level-Three chemical agents (such as nerve agents, mustards, mycotoxins, and selected toxic industrial chemicals). Level-Three Laboratories will also provide surge capacity to CDC and serve as referral laboratories for Level-One and Level-Two laboratories. The five laboratories currently funded under Focus Area D (California, Michigan, New Mexico, New York and Virginia) are considered Level-Three laboratories. It is CDC's intent in the future to add up to five additional laboratories at Level-Three

Focus Area E - Health Alert Network/Communications and Information Technology:
Enable state and local public health agencies to establish and maintain a network that will (a) support exchange of key information and training over the Internet by linking public health and private partners on a 24/7 basis; (b) provide for rapid dissemination of public health advisories to the news media and the public at large; (c) ensure secure electronic data exchange between public health partners' computer systems; and (d) ensure protection of data, information, and systems, with adequate backup, organizational, and surge capacity to respond to bioterrorism and other public health threats and emergencies

Critical and Enhanced Capacities:

- *Critical:* To ensure effective communications connectivity among public health departments, healthcare organizations, law enforcement organizations, public officials, and others (e.g., hospitals, physicians, pharmacies, fire departments, 911 centers)
- *Critical:* To ensure a method of emergency communication for participants in public health emergency response that is fully redundant with standard Telecommunications (telephone, e-mail, Internet, etc.)
- *Critical:* To ensure the ongoing protection of critical data and information systems and capabilities for continuity of operations in accordance with IT function #8 (see Appendix 4)
- *Critical:* To ensure electronic exchange of clinical, laboratory, environmental, and other public health information in standard formats between the computer systems of public health partners. Achieve this capacity according to the relevant IT Functions and Specifications
- *Enhanced:* To provide or participate in an emergency response management system to aid the deployment and support of response teams, the management of response resources, and the facilitation of inter-organizational communication and coordination
- *Enhanced:* To ensure full information technology and support services

Focus Area F – Communicating Health Risks and Health Information Dissemination:
Ensure that state and local public health organizations develop an effective risk communications capacity that provides for timely information dissemination to citizens during a bioterrorist attack, outbreak of infectious disease, or other public health threat or emergency. Such a capacity should include training for key individuals in communication skills, the identification of key spokespersons (particularly those who can deal with infectious diseases), printed materials, timely reporting of critical information, and effective interaction with the media

Critical and Enhanced Capacities:

- *Critical:* To provide needed health/risk information to the public and key partners during a terrorism event by establishing critical baseline information about the current communication needs and barriers within individual communities, and identifying effective channels of communication for reaching the general public and special populations during public health threats and emergencies
- *Enhanced:* To identify, develop, and pretest communication concepts, messages, and strategies to ensure that state and local public health agencies prepare in advance and produce effective and culturally appropriate public information for terrorism, other infectious disease outbreaks, and other public health threats and emergencies

Focus Area G - Education and Training:
Ensure that state and local health agencies have the capacity to (a) assess the training needs of key public health professionals, infectious disease specialists, emergency department personnel, and other healthcare (including mental health) providers related to preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies, and (b) ensure effective provision of needed education and training to key target audiences through multiple channels, including Centers for Public Health Preparedness, other schools of public health, schools of medicine, other academic institutions, healthcare professionals, CDC, HRSA, and other sources

Critical and Enhanced Capacities:

- *Critical:* To ensure the delivery of appropriate education and training to key public health professionals, infectious disease specialists, emergency department personnel, and other healthcare (including mental health) providers in preparedness for and response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies, either directly or through the use (where possible) of existing curricula and other sources, including Centers for Public Health Preparedness, other schools of public health, schools of medicine, academic health centers, CDC training networks, and other providers
- *Enhanced:* To ensure that public and private health professionals and other members of the community are identified in advance and can be effectively trained to mobilize and respond during a public health emergency
- *Enhanced:* To provide directly or through other organizations the ongoing systematic evaluation of the effectiveness of training, and the incorporation of lessons learned from performance during bioterrorism drills, simulations, other exercises, events, and evaluations of those exercises.

E. SUBMISSION REQUIREMENTS AND DEADLINE

Continuation applications are due on July 1, 2003. CDC intends to provide an Internet-based system for submitting continuation applications electronically. This system will enable applicants to complete required forms electronically, with the exception of Grant forms (see below). Applicants are strongly encouraged to use this system in lieu of paper-based applications. Under separate cover, CDC will provide detailed instructions to obtain a digital certificate to access the CDC web portal https://sdn.cdc.gov/ and use the electronic application

system. Any questions or problems concerning use of the Internet-based application should be directed to your project officer.

1. Grant Application Forms

Forms SF-424, SF-424A, SF-424B and PHS 5161-1 (checklist) must be printed, signed and mailed to the CDC Procurement and Grants Office. (The remainder of the application, along with the required forms, can be submitted electronically.)

* Form PHS 5161-1 is available from the CDC Procurement and Grants office at the following Internet address: http://www.cdc.gov/od/pgo/forminfo.htm.

* Forms SF-424 and SF-424B are available from the Office of Management and Budget and are available at the following Internet address: http://www.whitehouse.gov/omb/grants/grants_forms.html

* Form SF-424A will be generated and pre-populated automatically from the SLPPMIS budget application site. A blank form SF-424A can also be obtained at the following Internet address: http://www.whitehouse.gov/omb/grants/grants_forms.html

Applications must include a projection of the amount of FY2002 supplemental funds (awarded in February and June, 2002) that will be unobligated at the end of Budget Period Three (i.e., on August 30, 2003) and report this estimate for each focus area on a separate interim FSR form. (See Unobligated Funds, under B. AVAILABILITY OF FUNDS.)

2. Application Narrative and Budget

Applicants should access the electronic application system at the CDC portal https://sdn.cdc.gov/ and follow the online instructions to download, complete and upload MS WORD templates for the narrative sections described below (Component A and Component B). The budget section can be completed directly online and submitted to CDC, along with the uploaded narratives (8 total documents), via the web portal.

Part I - HRSA/CDC Cross-Cutting Narrative

The Part I template provides for responses to the questions and answers for cross-cutting coordination benchmarks and activities in Attachment X. These cross-cutting issues reflect the broader Departmental goals and represent a unified set of objectives that incorporate the sense of both the CDC- and HRSA-specific requirements. The information entered in this template should be identical to that submitted in the HRSA application. Thus, this response need be prepared only once and copies inserted in the separate submissions to CDC and to HRSA. This information will assist the Department of Health and Human Services in assessing the extent and nature of the efforts states are making to develop a cohesive and coherent approach for dealing with bioterrorism and other public health emergencies. *Please note the page limit requirements for each response stated in the template. These requirements are also stated in Attachment X.*

Part II – Public Health Preparedness Narrative

This component comprises the main body of the application and includes a template for a progress report and a work plan for each Focus Area. To facilitate completion by multiple individuals, the narrative portion has been broken into a separate MS WORD documents for Focus Areas A through G. Each Focus Area template has two sub-sections: (1) Interim Progress Report and (2) Work Plan which are described below.

(a) Interim Progress Report for Budget Period Three

Using the templates provided, applicants must provide a brief status report that describes progress made toward achievement of each of the *critical capacities* and *critical benchmarks* outlined in the continuation guidance issued by CDC in February 2002. Applicants should describe their agency's overall success in achieving each critical capacity, and specifically address whether or not the activities to meet the critical benchmarks have been completed. The response boxes will expand as text is added, however, the progress report narratives *should not exceed one page, single-spaced* for each critical capacity.

(b) Work Plan for Budget Period Four

Work plans should address all of the recipient activities under the Critical Capacities outlined in Attachments A-G. For each recipient activity, applicants should use the work plan template to outline the following:

- The strategy that will be used;
- The key activities which will be undertaken;
- The individual and/or organizational entity responsible for completing each key activity;
- The timeline for the activities; and
- The milestones and objective measures that will be used to track progress and facilitate accountability.

Awardees should use the suggested *Recipient Activities* in Attachments A-G when addressing Enhanced Capacities in their work plan.

Work plans should demonstrate meaningful collaboration between state and local public health agencies, as outlined in the joint *Association of State and Territorial Health Officials (ASTHO)-National Association of County and City Health Officials (NACCHO) Principles of Collaboration* (http://www.naccho.org/general483.cfm). Emphasis will be placed on allocating needed resources (including funding) among state and local public health agencies to achieve preparedness.

There is no limit to the length of each response; however, the responses should be brief and specific to the questions being asked.

Budget and Budget Justification

Unlike the narrative sections, the budget section is integral to the application accessed through the web portal https://sdn.cdc.gov/. Instructions are available on this website to guide you through the budget development and submission process. Please note that costs associated with the Strategic National Stockpile (SNS) -- formerly the National Pharmaceutical Stockpile -- should be documented separately from other costs related to Focus Area A. To accommodate this, the electronic budget application permits entry of costs separately for Focus Area A–SNS vs Focus Area A–Non SNS. Also, for each budget item, there is an area to indicate what percentage of that line item budget amount is used for Smallpox preparedness. There is also an area to indicate what percentage of each allocation is related to IT work activities and resources.

3. Submission

To submit the narrative and budget sections of the application electronically, follow the online instructions. This will signal CDC that the application is ready for review and prevent any further changes to the application by the applicant, pending any recommendations from the project officer. The electronic submission process must be completed by the application deadline (midnight on July 1, 2003).

Note that the budget forms (SF-424A AND SF-424B) must be printed out and mailed along with Form SF-424 and PHS 5161-1 (checklist) to the CDC Procurement and Grants Office by the submission deadline.

For awardees not submitting applications electronically, CDC must receive the original and two paper copies of the entire continuation application package on or before the July 1, 2003 deadline.

Please mail the Grant and Budget forms to:

Elmira C. Benson, Acting Chief (State and Local Grantees)
Attn: Sharon Robertson
Acquisition and Assistance Branch B
Procurement and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Telephone: 770-488-2748
Email Address: sqr2@cdc.gov

Rebecca B. O'Kelley, Chief (Territories)
Attn: Angelia Hill
International & Territories Acquisition and Assistance Branch
Procurement and Grants Office

Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Telephone: (770) 488-2785
Email Address: aph8@cdc.gov

F. TECHNICAL REPORTING REQUIREMENTS

1) **Progress Report for Budget Period Three** – A final progress report for activities undertaken in budget period 3 in response to the supplemental guidance released in February, 2002 is due 30 days after the end of the budget period 3 (i.e., on September 30, 2003). CDC will provide awardees with a template that specifies the performance indicators awardees should address.

2) **Semi Annual and Annual Progress Reports for Budget Period Four** - A semi-annual progress report for activities undertaken in budget period 4 must be included in your new cooperative agreement application that will be due in mid-2004; an annual report will be due 30 days after the end of the budget period, i.e., on September 30, 2004. CDC will provide templates for these reports to assess program outcomes related to activities undertaken using Budget period 4 funding.

3) **Financial Status Report –** A Financial Status Report is due 90 days after the end of the Budget period, November 30, 2004.

2) **Final Report** – This cooperative agreement will end on August 30, 2004. An original and two copies of the final Financial Status Report and a final program performance report for the project period (August 31, 1999 – August 30, 2004) are due to the Grants Management Officer named below on November 30, 2004.

Please submit your Reports to:

Elmira C. Benson, Acting Chief (State and Local Grantees)

Attn: Sharon Robertson
Acquisition and Assistance Branch B
Procurement and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Telephone: 770-488-2748
Email Address: sqr2@cdc.gov

Rebecca B. O'Kelley, Chief (Territories)
Attn: Angelia Hill
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Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Telephone: (770) 488-2785
Email Address: aph8@cdc.gov

Please copy your Project Officer on any electronic submissions.

G. WHERE TO OBTAIN ADDITIONAL INFORMATION

Business management technical assistance may be obtained from:

Sharon Robertson (State and Local Grantees)
Grants Management Specialist
Acquisition and Assistance Branch B
Procurement and Grants Office
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road, Room 3000
Atlanta, Georgia 30341-4146
Telephone: (770) 488-2748
E-mail address: sqr2@cdc.gov

Angelia Hill, Grants Management Specialist for Territories (Territories)
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Focus Area specific technical assistance for this supplemental request may be obtained from the enclosed contact list (Appendix 1).

H. APPENDICES:

1. Technical Assistance Contact List
2. HRSA Contact List
3. NEDSS Contact List
4. Public Health Information Technology Functions and Specifications for Emergency Preparedness and Bioterrorism
5. Direct Assistance Information
6. Progress Report and Workplan Templates

I. ANNEXES:

A. Summary of Smallpox Preparedness Activities
B. Funding Table